

Poverty and common sense evolution

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Paediatrics & Child Health has joined with more than 230 other medical journals focusing on poverty to coincide with World Poverty Day on October 17, 2007. In Canada, despite a long period of economic growth and record levels of wealth and profit, over one million Canadian children (one in six) live in poverty (1). Children (one in two) living with single mothers, children (one in two) from recent immigrant families and children (one in four on-reserve; one in three off-reserve) from Aboriginal families are over-represented among the poor.

Sir William Osler (2) and Dr Norman Bethune (3), among many others, recognized that wealth underscores health, and ill health is the birth right of the poor. Proper sanitation and the availability of clean air and water are key to the health of communities. However, only recently have we understood the pervasive influence of maternal health and good prenatal nutrition as a fundamental determinant of health. Newborn weight, it appears, predicts tissue plasticity, resilience and, ultimately, longevity in later life (4). Children with lower birth weights will die sooner of diabetes, cardiovascular disease and premature stroke (5). Ironically, we are seeing that children with low birth weight are at greater risk of subsequent overweight and obesity, with their attendant risks (6). This insidious expression of malnutrition is reflected in higher rates of overweight and obesity in the poorest regions of Canada, and will evolve to higher rates of diabetes and premature cardiovascular deaths later (7).

The appreciation of the relationship of poverty, poor health and increased social cost, coupled with a falling birth rate, has ignited a new age of pragmatic enlightenment – the common sense evolution. There is a growing realization that we share a common destiny as citizens of the same nation. Disparities among us will ultimately threaten our social stability. Our ability to compete economically as a nation depends on providing greater opportunity to our most disadvantaged. We are also beginning to appreciate that this is equally true for the nations of the globe.

Redistribution of wealth, accomplished through income tax and other government programs, is a key enabler of civil society. However, the political survival of a government often depends on what is offered to voters in the electoral basket of goodies. When it comes to budget making at

the federal level, there are many trade-offs ('opportunity costs') to consider. Take for example the 'poverty gap', which is the amount of money needed to bring all poor families with children up past the poverty line. In 2003, the poverty gap for single mothers with children was approximately \$5.7 billion, very close to the level by which the 1% goods and services tax cut is estimated to reduce federal tax revenues in 2007 (1). The government chose the politically expedient course.

In regard to health policy, successive federal governments have emphasized wait-time reductions for cardiac, cancer, eye and orthopedic care, and diagnostic imaging. While applauded by aging baby boomers, these initiatives also represent 'opportunity costs', and come at the expense of other critical areas of the health care system. Poor children, after all, usually live with their parent(s), who themselves are disproportionately burdened with addictions, mental health issues, adolescent pregnancies and domestic violence. What will diverting limited resources to federal wait-time initiatives mean for programs addressing these poverty-related children's health issues?

The Canadian Paediatric Society (CPS) has become an increasingly effective advocate for better government policy. The CPS has developed an advocacy tool kit to help members best leverage their influence with government politicians and bureaucrats (8). The biannual CPS status report rates provincial and federal governments' performance on many different measures important to child and youth health. It has become an important tool for reinforcing positive performance and encouraging responsive legislative, policy and fiscal measures. We hope to include antipoverty interventions in the next edition.

What can we do as individuals? As members of our community, we all support many worthy causes. Healthy Generations <www.healthygenerations.ca>, the CPS's foundation, offers a vehicle for personal support of worthy initiatives that are most important to paediatricians.

Equally valuable are donations of one's time and influence. Politicians often remind our Advocacy Committee that paediatricians occupy a unique role of public trust. Our dedication to improving the health and well-being of the nation's children and youth is well recognized. Public policies that promote a fair minimum wage (one in every four

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jobs in Canada pays less than \$10/h [1]), affordable housing, enforcement of safety measures and increase access to quality education deserve our support as physicians.

Fortunately, due to enlightened self-interest, the issue of addressing poverty has made inroads across a broad sweep of Canadian society. In Quebec, child poverty rates have been consistently declining since 1997 (1). In 2007, the Government of Ontario responded to a coalition of activists and business leaders and committed to social programs to give 1.3 million children from low-income

families a better start in life (9,10). A new five-year, \$2.1 billion child benefit program will allow parents to move off the welfare rolls without losing financial support for their children (11). We hope that this initiative stimulates other provinces to follow suit. But we must do more than hope. We must respectfully, diligently and persistently encourage governments to significantly reduce child poverty, both at home and abroad. We trust that reading this issue of *Paediatrics & Child Health* will stimulate you to consider new ways in which you and we can make a difference.

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